

01124

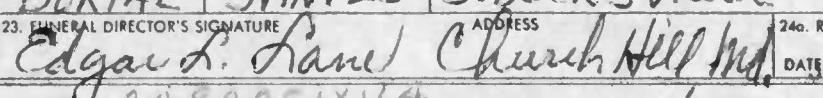
FOR STATE
HEALTH DEPT.

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1126 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Queen Anne's		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Queen Anne's		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Centreville		c. LENGTH OF STAY IN 1b 17 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X rural Centreville		d. STREET ADDRESS Conquest Farm		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Conquest Farm				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Sandra		First Jean	Middle Calloway	Lost	4. DATE OF DEATH Jan. 26	Month Jan.	Day 26	Year 16 6
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Jan. 6, 1960	9. AGE (In years last birthday) yrs. 20	IF UNDER 1 YEAR Months 20	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Paul Allen Calloway				14. MOTHER'S MAIDEN NAME Alice Wooleyhan				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Paul Calloway		Address Centreville, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Deferred/pending autopsy/ result INTERVAL BETWEEN ONSET AND DEATH 1/8 min								
754.6 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b) Heart failure rt sided				1 hour		
		DUE TO (c) Coarctation for 10 cm Aorta				4 weeks		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input checked="" type="checkbox"/>								
ACTUAL SIGNATURE 		EXAMINER'S NAME (Type) C. R. Layton, M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED Jan. 27, 1960		
220. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF JAN. 25		22c. NAME OF CEMETERY OR CREMATORIUM SUDLERSVILLE		22d. LOCATION (City, town, or county) (State) SUDLERSVILLE MD.		
23. FUNERAL DIRECTOR'S SIGNATURE 		ADDRESS Church Hill, Md.		24a. REC'D BY REGISTRAR DATE JAN 29 '60		24b. REGISTRAR'S SIGNATURE Caroline S. Thomas		

Catharrelle

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 1126 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01125

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
Queen Anne's MARYLAND		a. STATE M.D.	b. COUNTY Q.A.
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
Rural - Stevensville		3 yr.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First W. William	Middle JAMES
Last Coleman		4. DATE OF DEATH	Month Jan. Day 28 Year 1960
5. SEX Male		6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	APRIL 23 - 1897 62 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Laborer		Farming	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Virginia		U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes World War I		16. SOCIAL SECURITY NO. 17. INFORMANT	
		Phillip Davidson Address Stevensville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Occlusion			
DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)			
DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		DATE SIGNED 1/28/60	
ACTUAL SIGNATURE Irvin G. Hoyt		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Irvin G. Hoyt MD		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> (Asst)	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL Jan 30 - 60		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORIAL Churchill		22d. LOCATION (City, town, or county) Church Hill Rural, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Edgar L. Kane / Funeral Director		ADDRESS	
		24a. REC'D BY REGISTRAR FEB 2 '60	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Farm PM3. Page 5 may be retained for your files.

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VS. A1SME(S)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1127 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

01126

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
<i>Queen Anne's MARYLAND</i>		a. STATE <i>Po2</i>	b. COUNTY <i>Unknown</i>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
<i>Chester Md</i>		<i>4 days</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
<i>None</i>		<i>Buttonwood Hotel</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Morris</i>	Middle <i>Chester Jones</i>	Last 4. DATE OF DEATH <i>Jan 20 1960</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb 23, 1904</i>
9. AGE (In years last birthday) <i>53 yrs.</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Tester</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Westinghouse Salisbury Md</i>	11. BIRTHPLACE (State or foreign country) <i>USA</i>
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	13. FATHER'S NAME <i>Winer Chester Jones</i>		
14. MOTHER'S MAIDEN NAME <i>Minnie Morris</i>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		
16. SOCIAL SECURITY NO. <i>410 Gun Shot Wound Penetrating Head</i>	17. INFORMANT <i>Morris Jones Jr - Chester Md</i>	Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>976x</i> DUE TO <i>Gun Shot Wound Penetrating Head</i> None			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <i>Deep Depression</i> 4 days			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>410 Gun Shot Wound Self inflicted</i>	
20c. TIME OF INJURY <i>10:00 a.m.</i>	Month, Day, Year <i>1-20-1960</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Sons home</i>
20f. (City or town) <i>Chester QA</i>	(County) <i>Md</i>	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>C. R. Layton</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <i>1-20-60</i>
EXAMINER'S NAME (Type) <i>C. R. Layton</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	22b. DATE THEREOF <i>JAN. 22</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>MEMORIAL PARK</i>	22d. LOCATION (City, town, or county) <i>SALISBURY MD.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edgar L. Hane Church Hill, Md.</i>		ADDRESS	24a. REC'D BY REGISTRAR DATE <i>JAN 27 '60</i>
			24b. REGISTRAR'S SIGNATURE <i>Charles S. Thorne</i>

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

V.S. A15ME
SM 2/57

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1128

01127

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE	
Queen Anne's MARYLAND		Maryland b. COUNTY Queen Anne's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
nr. Chestertown		X RFD Church Hill Md.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First	Middle
Winifred Emma Liles			
4. DATE OF DEATH		Month	Doy
Jan. 23		1960	
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH
Female	white	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Dec. 12, 1915
9. AGE (In years last birthday)		10. UNDER 1 YEAR IF UNDER 24 HRS.	
44 yrs.		Months	Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Housewife		own home	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Maryland		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Fred W. Norris		Mabel Turner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 17. INFORMANT	
no		none Mrs. Fred W. Norris Church Hill, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Compound fracture of skull with br. damage	
822X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		DUE TO crushing injury to chest	
(b)		Auto accident	
(c)		Instant	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
should d thrown from carwhich rolled over 3 times after hitting			
20c. TIME OF INJURY Month, Day, Year Hour		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>	
2:50 p.m. Jan. 23, 60		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
		Highway nr. Chestertown Q.A. Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
ACTUAL SIGNATURE <i>C. R. Leyton</i>		DATE SIGNED	
EXAMINER'S NAME (Type) C. R. Leyton		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
220. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF JAN. 26	
22c. NAME OF CEMETERY OR CREMATORI		22d. LOCATION (City, town, or county) Church Hill	
23. FUNERAL DIRECTOR'S SIGNATURE Edgar S. Lane		24a. REC'D BY REGISTRAR Jan. 23, 1960	
ADDRESS		24b. REGISTRAR'S SIGNATURE	
Chuch Hill, Md.		Arthur S. Krause	
DATE JAN 27 '60			

WILLIAM L. DAVIS - DEATH-CERTIFICATE

STATE OF

DEPT. OF

2

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

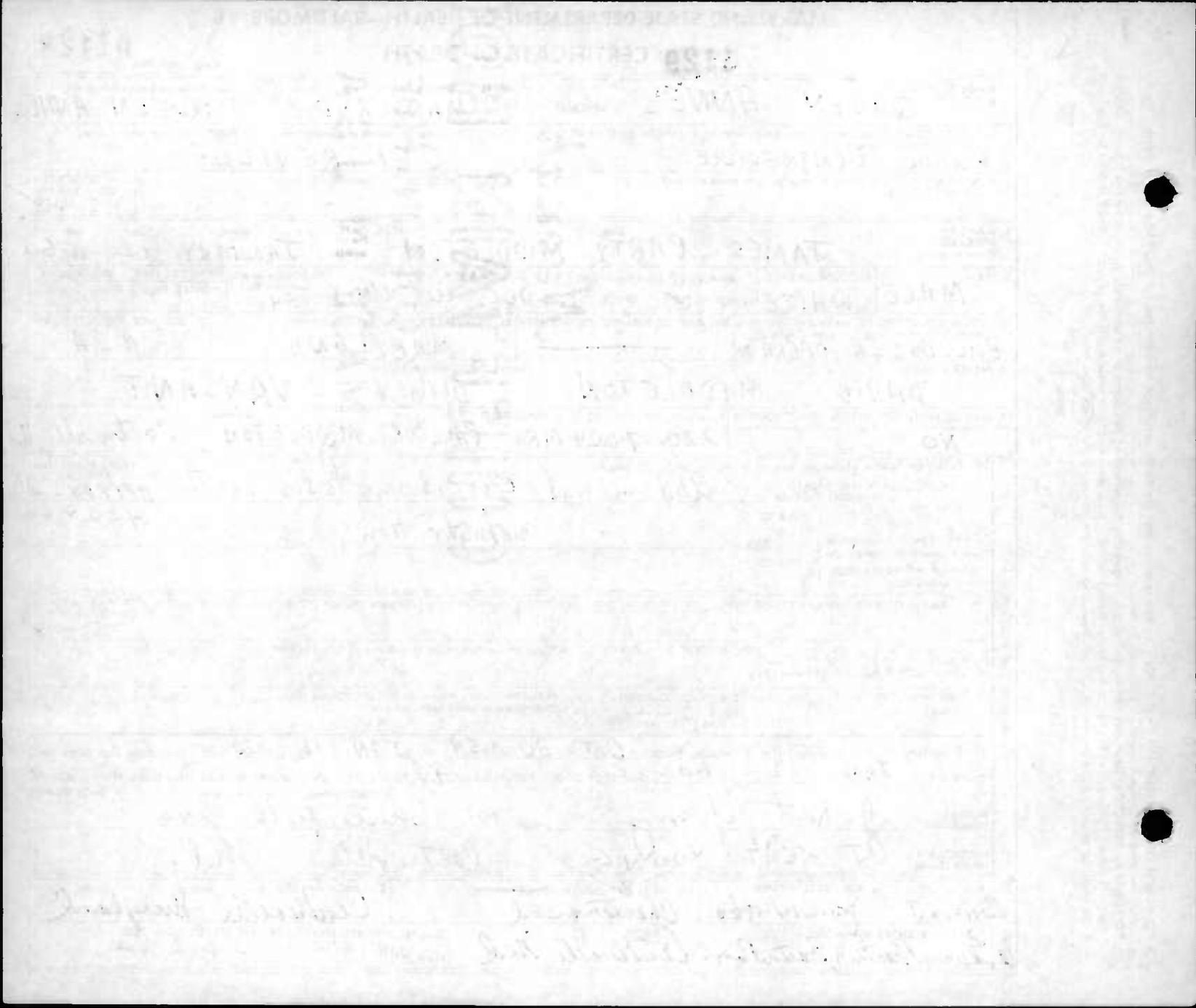
1129 CERTIFICATE OF DEATH

Reg. Dist. No.

01128

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY QUEEN ANNE'S MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY QUEEN ANNE'S	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - CENTREVILLE		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X CENTREVILLE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First JAMES MIDDLETON Middle LOST		4. DATE OF DEATH Month JANUARY Day 12 Year 1960	
5. SEX MALE COLOR OR RACE WHITE 6. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 7. WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH DEC. 10, 1905 9. AGE (In years lost birthday) 54 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BULLDOZER OPERATOR		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME DAVID MIDDLETON		14. MOTHER'S MAIDEN NAME MARY VANSANT	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? NO (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 220-07-0024 INFORMANT MRS. PAULINE MIDDLETON, Centreville, Md Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 199.2 DUE TO Abdominal carcinomatosis with Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH APPROX. 2½ years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While not while of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct. 30, 1959 to JAN. 12, 1960, that I last saw the deceased alive on JAN. 12, 1960, and that death occurred at 9:15 A.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) M.D. 105 Chesterfield Ave. Centreville, Md.	
ACTUAL SIGNATURE J. KENT YOUNG		DATE SIGNED	
PHYSICIAN'S NAME (Type) J. KENT YOUNG			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan 14-1960	
22c. NAME OF CEMETERY OR CREMATORIUM Chesterfield		22d. LOCATION (City, town, or county) (State) Centreville Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Barton Jr. Barton Bros. Centreville Md		24a. REC'D BY REGISTRAR DATE JAN 14 '60	
ADDRESS		24b. REGISTRAR'S SIGNATURE Arthur S. Trahan	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1130

CERTIFICATE OF DEATH

Reg. Dist. No.

01129

1. PLACE OF DEATH a. COUNTY Queen Anne		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Stevensville		c. LENGTH OF STAY IN 1b 40 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION —		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Roxanna		First —	Middle —
4. DATE OF DEATH JAN. 28 1960		Last PALMER	Month —
5. SEX FEM.	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 27-1868
9. AGE (In years last birthday) 91 yrs.		10. IF UNDER 1 YEAR Months —	11. IF UNDER 24 HRS. Days —
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME CARMINE		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO. 17. INFORMANT PAUL PALMER - Stevensville	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure		INTERVAL BETWEEN ONSET AND DEATH one week	
420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Coronary atherosclerosis, coronary		DUE TO several years	
{ DUE TO atherosclerotic heart disease		several years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) nodular goitre (isthmus) 35 years	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Stevensville		20f. (City or town) (County) (State) Stevensville MD	
21. I certify that I attended the deceased from Jan. 10, 1940 to Jan. 28, 1960 , that I last saw the deceased alive on January 27, 1960 , and that death occurred on Jan. 28, 1960 at A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Theodor Sattelmair		ADDRESS (Street, city or town, state) Stevensville, Maryland	
PHYSICIAN'S NAME (Type) Theodor SATTELMAYER		DATE SIGNED Jan 29, 1960	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-30-60	
22c. NAME OF CEMETERY OR CREMATORIUM Stevensville		22d. LOCATION (City, town, or county) Stevensville Ind.	
23. FUNERAL DIRECTOR'S SIGNATURE Edgar Jane Church Hill Ind.		24a. REC'D BY REGISTRAR DATE FEB 2 '60	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1131 CERTIFICATE OF DEATH

Reg. Dist. No. 01130

1. PLACE OF DEATH a. COUNTY Queen Anne's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Queen Anne's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greenville (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greenville (Rural)	
NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) FANNIE JULIA		First	Middle
		Price	Last
4. DATE OF DEATH		Month	Day Year
S. SEX female	6. COLOR OR RACE Col.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 10 - 1916
9. AGE (In years lost birthday) 63 yrs.		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Oyster Shucker		10b. KIND OF BUSINESS OR INDUSTRY Oyster Packer	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ?		14. MOTHER'S MAIDEN NAME Johnson Daves	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-18-5362	
17. INFORMANT		Address 1344 1st St. Cambridge Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH Jan. 19, 1960.	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cerebral hemorrhage (ruptured aneurysm)		DUE TO	
Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost.		(b) arteriosclerosis cerebral & general several years	
DUE TO		(c) hypertension cardio - renal disease	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 29, 1959, to January 19, 1960, that I last saw the deceased alive on Jan. 19, 1960, and that death occurred at 2 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Theodor Sattelmayer M.D.		ADDRESS (Street, city or town, state) STEVENSVILLE, MD. DATE SIGNED Jan. 20, 1960	
PHYSICIAN'S NAME (Type) Theodor SATTELMAYER		STEVENSVILLE, MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 20, 1960	
22c. NAME OF CEMETERY OR CREMATORIUM Chester		22d. LOCATION (City, town, or county) (State) Chester Maryland	
23. FUNERAL-DIRECTOR'S SIGNATURE Wm. J. Gandy, Director of Deaths, Belvoir, Md.		ADDRESS	
24a. REC'D BY REGISTRAR DATE JAN 25 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Pearce	

TO HOSPITAL or **TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MISSOURI STATE DEPARTMENT OF HEALTH—DIVISION OF

CERTIFICATE OF DEATH

1133

DECEASED

NAME

ADDRESS

PHONE

AGE

SEX

RACE

RELIGION

EDUCATION

EMPLOYMENT

DEATH DATE

TIME

CAUSE

DEATH PLACE

DEATH NUMBER

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01131

FOR STATE
HEALTH DEPT.

Reg. Dist. No.

1132

1. PLACE OF DEATH a. COUNTY Q. A.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Q. A.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) near Church Hill		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sudlersville			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2 Mi. South Church Hill Off Rt. 21		d. STREET ADDRESS Roe Hill		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Dudley G.	Middle Roe	Last III	4. DATE OF DEATH	Month Jan.	Day 30	Year 1960
5. SEX M.	6. COLOR OR RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 16 1932	9. AGE (In years from birthday) 28 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Grain Dealer		10b. KIND OF BUSINESS OR INDUSTRY Corn & Feed		11. BIRTHPLACE (State or foreign country) Roanoke Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Dudley G. Roe Jr.		14. MOTHER'S MAIDEN NAME Elsie Moir					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-30-9200		17. INFORMANT Elsie E. Roe		Address Sudlersville Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 866X DUE TO Multiple Extreme Injuries with Conditions, if any, which gave rise to immediate cause (b) CRUSHING of chest and Fractures (c) of SKULL INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. NATIONAL GUARD (Army) Plane crashed in field YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>					
20c. TIME OF INJURY Month, Day, Year 1/30 p.m.		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> of work <input checked="" type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Field		20f. (City or town) (County) (State) 2 miles S. of CHURCH HILL B.R.A. MD	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE R. S. Fisher		M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 1/31/60	
EXAMINER'S NAME (Type) R. S. Fisher		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 2/60		22c. NAME OF CEMETERY OR CREMATORIUM Sudlersville Cemetery		22d. LOCATION (City, town, or county) (State) Sudlersville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Marvin V. Williams		ADDRESS Chestertown, Md.		24a. REC'D BY REGISTRAR FEB 2 '60		24b. REGISTRAR'S SIGNATURE Charles L. Branch	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

